

2092

CERTIFICATE OF DEATH

02080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage c. LENGTH OF STAY IN 1b 30 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage d. STREET ADDRESS Commercial St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emory C. Condon		4. DATE OF DEATH Month Day Year Feb. 1 - 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill	
11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward F. Condon		14. MOTHER'S MAIDEN NAME Sarah J. West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-01-7668	
17. INFORMANT James H. Condon, Savage, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Asthmatic attacks 241X DUE TO Chr. Asthma Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Myocardial Insuff. INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) th		20f. (City or town) (County) (State) Savage, Md.	
21. I certify that I attended the deceased from Jan. 27, 1960 to Feb. 1st 1960 that I last saw the deceased alive on Feb. 1st 1960 and that death occurred at 10:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Frank E. Shipley M.D. ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED PHYSICIAN'S NAME (Type) Frank E. Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 1960	
22c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		22d. LOCATION (City, town, or county) (State) Savage, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Connelton, Laurel, Md		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician must be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

121030

RECEIVED
OFFICE OF THE
DIRECTOR
121030

1

121030

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, consisting of several paragraphs of a memorandum format.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2094

CERTIFICATE OF DEATH

Reg. Dist. No.

02082

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup				c. LENGTH OF STAY IN b. X Jessup			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ROSELIN Middle HARDING Last HARDING				4. DATE OF DEATH Month Feb. Day 6 Year 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1959	
9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months 5 Days 28 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Harding				14. MOTHER'S MAIDEN NAME Hilda Carroll Coleman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Harding Address Jessup, Md. Box 179	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Virus Infection 096.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26 , 19 59 to 2/6 , 19 60 that I last saw the deceased alive on 2/6 , 19 60 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J M Warren M.D. Racine 2/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY Guilford Baptist.,	
22d. LOCATION (City, town, or county) (State) Jessup, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Harwood ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE FEB 10 '60		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2038181XV4

CERTIFICATE OF DEATH

3094

10-15

Form with multiple sections for recording death information, including fields for name, date, time, place, cause of death, and signature. The form is partially filled out with handwritten text.

NAME: [illegible]
DATE: [illegible]
TIME: [illegible]
PLACE: [illegible]
CAUSE OF DEATH: [illegible]
SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2093

CERTIFICATE OF DEATH

02083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>			
c. LENGTH OF STAY IN TB <u>34 years</u>				d. STREET ADDRESS <u>1 Guilford Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Guilford Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES L. HEISHMAN</u>				4. DATE OF DEATH Month Day Year <u>February 12 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1908</u>		9. AGE (In years last birthday) <u>51 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (State or foreign country) <u>Edinburgh Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Heishman</u>				14. MOTHER'S MAIDEN NAME <u>Ada Laura Litten</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2-8-26-2007</u>		17. INFORMANT Address <u>Mrs. Elma Heishman, Savage Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis Liver</u> 260X DUE TO (b) <u>Alcoholic Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Metastatic Carcinoma site unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 years</u> <u>10 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/23, 1944</u> , to <u>2/12, 1960</u> , that I last saw the deceased alive on <u>2/2, 1960</u> , and that death occurred at <u>6:19 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. M. Warren</u>				DATE SIGNED <u>2/14/60</u>			
PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Savage Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edwitt Davidson, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CERTIFICATE OF DEATH

1903

1903

IN THE

DEPARTMENT

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2088

CERTIFICATE OF DEATH

02084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 12 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Michigan City 52 X-3				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadie Middle Hirsch Last Hirsch				4. DATE OF DEATH Month February Day 29 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov 7, 1899	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Ignatz Kline				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT hospital record Taylor Manor Hosp Ellicott	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Schizophrenia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Schizophrenia				INTERVAL BETWEEN ONSET AND DEATH 1 week			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Apr 27 , 19 57 , to Feb 29 , 19 60 , that I last saw the deceased alive on Feb 29 , 19 60 , and that death occurred at 8 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Taylor Manor Hospital DATE SIGNED 2/29/60 ACTUAL SIGNATURE Irving J. Taylor M.D. Taylor Manor Hospital, Ellicott City, Md PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 3/3/60		22c. NAME OF CEMETERY OR CREMATORY Greenwood	
22d. LOCATION (City, town, or county) (State) Michigan City, Ind							
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
24b. REGISTRAR'S SIGNATURE William S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville, 28</u> 0252			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cavey Lane</u>				d. STREET ADDRESS <u>2202 Rock Haven Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> <u>Henry</u> <u>Hoke</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Klingerstown, Pa</u>			
13. FATHER'S NAME <u>William Hoke</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-05-9440</u>		17. INFORMANT <u>Mrs. Clara M. Hoke, Catonsville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH - <u>10 min.</u> <u>1 year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>George E. Burgtorf</u>		NAME (Type) <u>George E. Burgtorf M D</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview</u>			
22d. LOCATION (City, town, or county) (State) <u>Bt. 26 Baltimore County, Md</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE <u>FEB 9 '60</u> <u>Arthur J. Hines</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham Ellicott City Md</u>							

MEDICAL CERTIFICATION

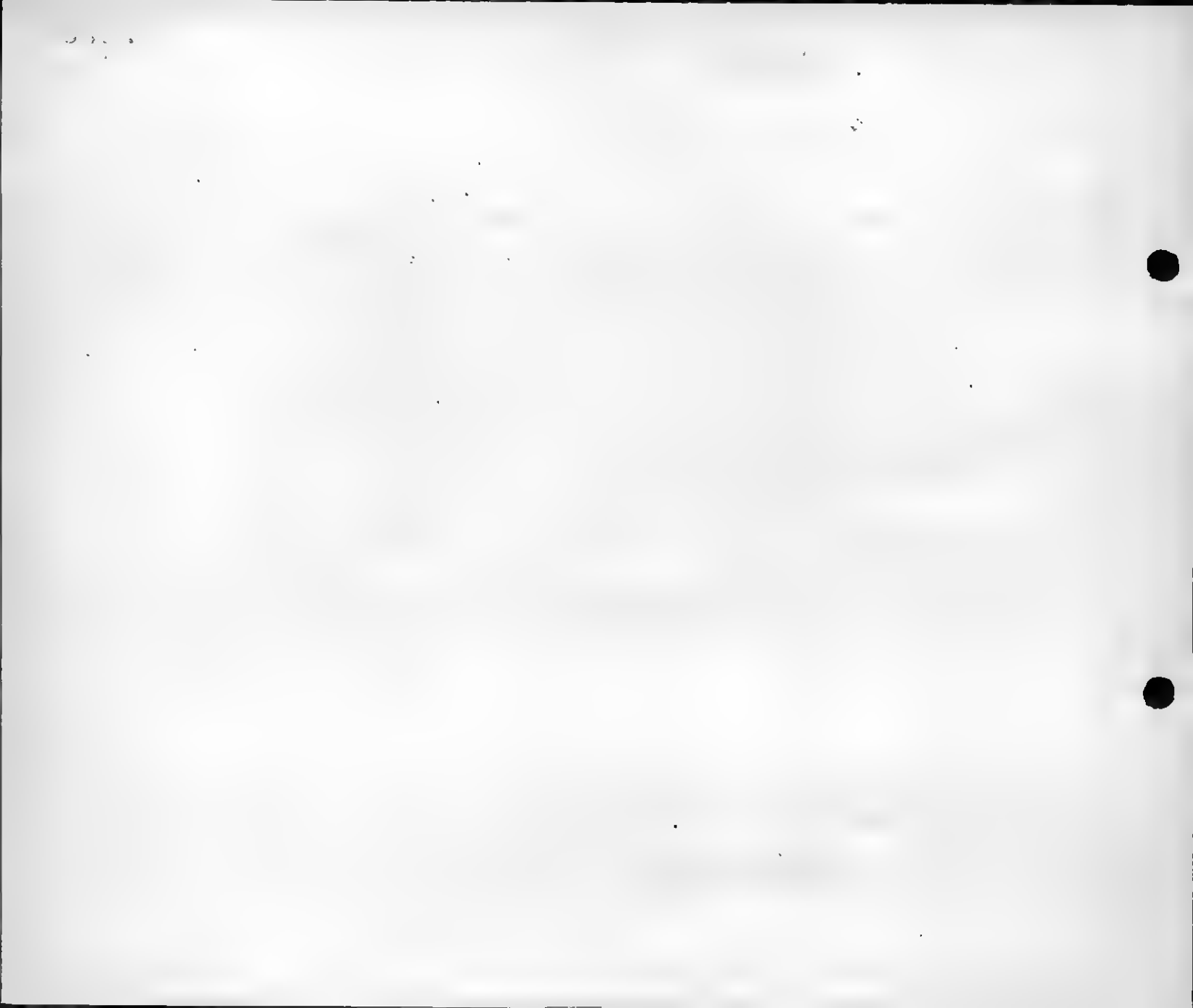
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2096 CERTIFICATE OF DEATH

02086

1. PLACE OF DEATH a. COUNTY <i>Howard</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Marriottsville</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>JAMES EMORY JOHNSON</i>				4. DATE OF DEATH <i>Feb. 14 1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10 1877</i>	9. AGE (In years lost birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>labour</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Johnson</i>				14. MOTHER'S MAIDEN NAME <i>Ruby Davis</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure, coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>edema - arteriosclerosis generalized</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <i>1559 to 14 Feb 60</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> 19 to <i>14 Feb</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>14 Feb</i> 19 <i>60</i> , and that death occurred at <i>5 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hall</i>				22b. DATE SIGNED <i>2/15/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				22d. ADDRESS <i>Aqueduct, Md.</i>			
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE THEREOF <i>2-17-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Liberty</i>		23d. LOCATION (City, town, or county) (State) <i>Albany, Howard Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>				25a. REC'D BY REGISTRAR <i>Feb 19 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

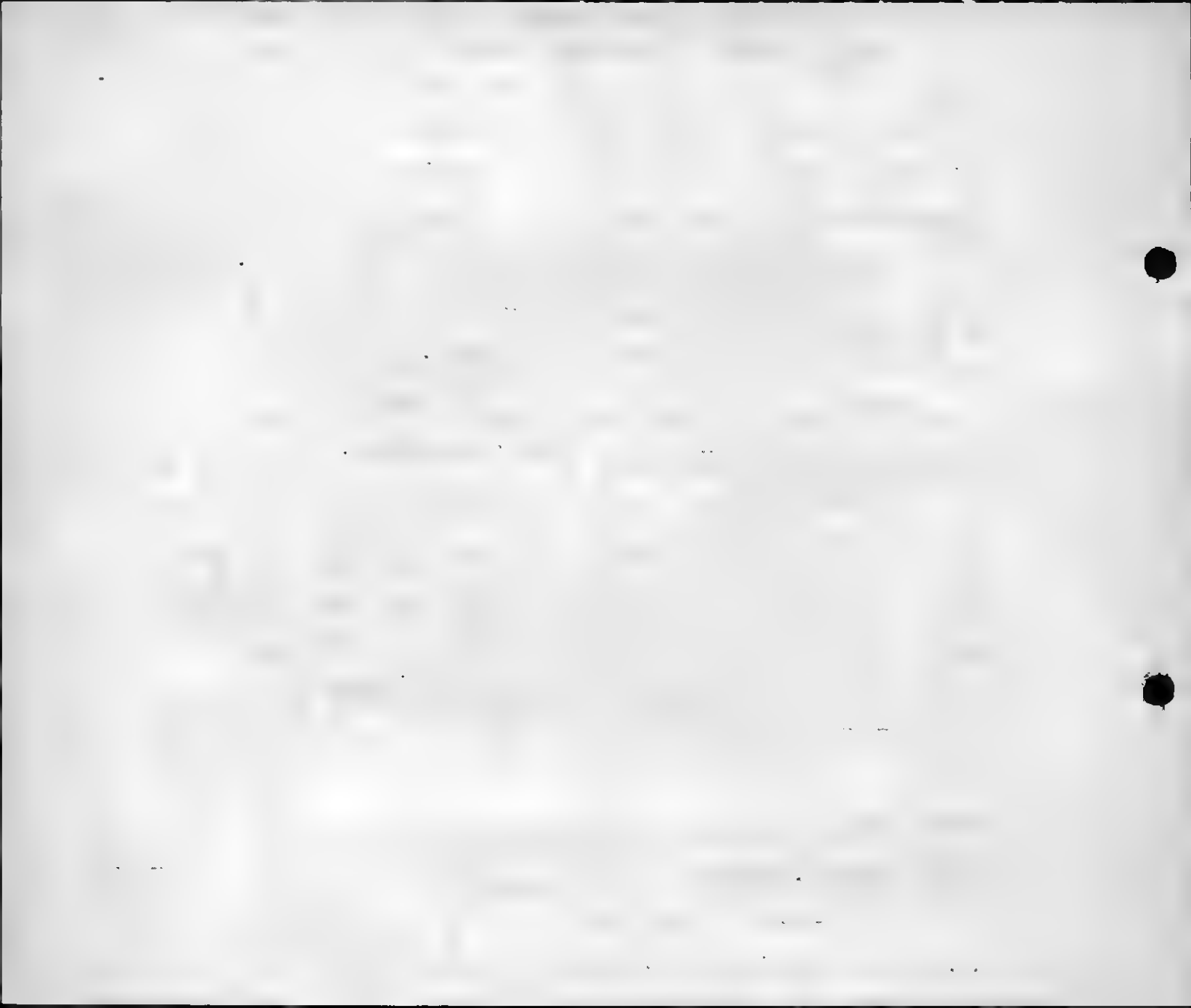
2097

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups c. LENGTH OF STAY IN 1b Jessups d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Berger Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups d. STREET ADDRESS Berger Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN CATHERINE KAHLER First Middle Last		4. DATE OF DEATH Month Day Year Feb. 10, 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-1899
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	11. BIRTHPLACE (State or foreign country) Ednor, Md
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Coar	
14. MOTHER'S MAIDEN NAME Mary Harding		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Adam Kahler, Jessups, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Strangulation by hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Strangulation by hanging (self inflicted)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 5 p. m. 2-10-60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Home		20f. (City or town) (County) (State) Jessups Howard Co Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George E. Burgtorf EXAMINER'S NAME (Type) George E. Burgtorf M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-12-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-60	
22c. NAME OF CEMETERY OR CREMATORY St Pauls		22d. LOCATION (City, town, or county) (State) Fulton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



2089

CERTIFICATE OF DEATH

02088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN lb 6 days				d. STREET ADDRESS 2812 N. Loudon Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William L Mazaroff				4. DATE OF DEATH Month Day Year Feb. 16 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 13, 1890	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant- retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Abraham				14. MOTHER'S MAIDEN NAME Tola			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Bert Mazaroff Address Son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary edema bilateral 480x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial failure, rt. sided 72 hrs. (c) Influenza with broncho-pneumonia 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 10, 1960, to Feb 16, 1960, that I last saw the deceased alive on Feb 16, 1960, and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stephen Lee Magness M.D. Taylor Manor Hospital 2/16/60 PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hosp. Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-60		22c. NAME OF CEMETERY OR CREMATORY United Hebrew		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Levin 2100 Eutaw Place				24a. REC'D BY REGISTRAR DATE FEB 18 60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.



2090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 1-11-11 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 0353.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 3023 Dunglew Road	
3. NAME OF DECEASED (Type or print) First George Middle R. Last Norris		4. DATE OF DEATH Month Feb. Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 27, 1891
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Dealer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore County	
11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jacob Norris		14. MOTHER'S MAIDEN NAME Elizabeth ??(Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 213-28-6986	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 1 hr. unknown unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome, associated with cerebral psychosis a.s. with paranoia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 13 , 19 58 , to Feb 15 , 19 60 , that I last saw the deceased alive on Feb 15 , 19 60 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Taylor Manor Hospital DATE SIGNED 2/15/60			
ACTUAL SIGNATURE Stephen Lee Magness M.D. Taylor Manor Hospital 2/15/60			
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hospital, Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/60	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		24a. REC'D BY REGISTRAR DATE FEB 17 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove rubber papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2098

2098
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02090

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
3. NAME OF DECEASED (Type or print) <u>WINFIELD S. PARKER</u>		d. STREET ADDRESS <u>Bucky Park Road</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>col</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hennis Parker</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Cassaway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs Virginia Parker - Cooksville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchial pneumonia, cardiac</u> 471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>failure, coronary thrombosis, arteriosclerosis generalized</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 Hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Feb 14 1960</u> that (I) (we) last saw the deceased alive on <u>14 Feb 1960</u> and that death occurred at <u>6:15 P</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Howard E. Hall</u> M.D.		22b. DATE SIGNED <u>2/15/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		22d. ADDRESS <u>Cooksville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-18-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bucky Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cooksville, Howard, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Haight</u> ADDRESS <u>Cooksville, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 19 60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



2093

CERTIFICATE OF DEATH

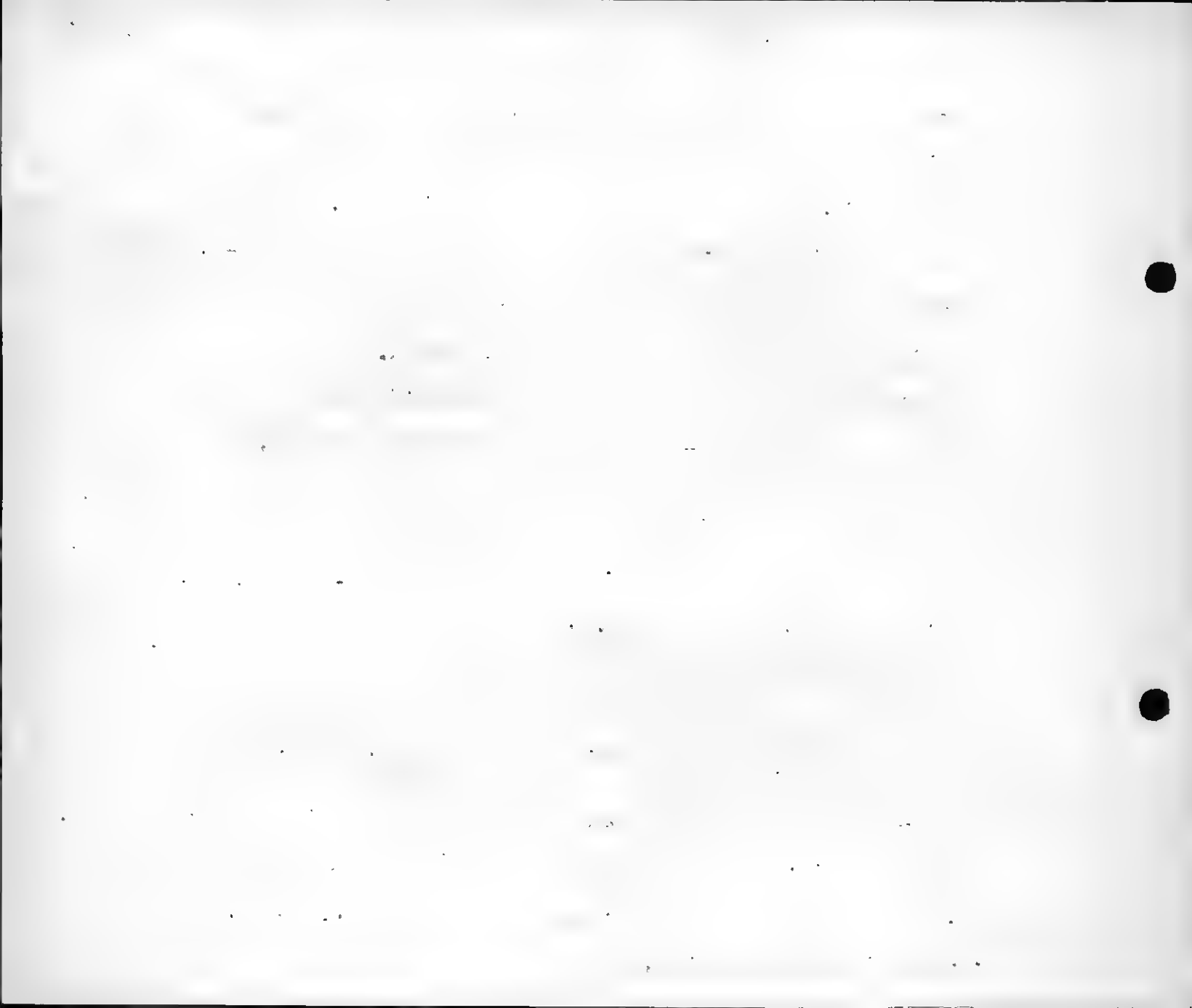
02091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Res. dence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5609 Main St.						d. STREET ADDRESS Meadowridge Ave. Box 314				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSANNA PETERSON		First		Middle		Last		4. DATE OF DEATH Month 2-22-1960		Day 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28-1891		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Louise Tiechman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-34-1615		INFORMANT Howard Peterson, Elkridge, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 2 hrs 420.1 DUE TO (b) Cardio Vascular Disease 5 1/2 hrs Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Arterial Hypertension 5 1/2 hrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Obesity											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Elkridge		(County) (State)	
21. I certify that I attended the deceased from Jan 20, 1960 to Feb 22, 1960 , that I last saw the deceased alive on Feb 22, 1960 and that death occurred at 10:25 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5609 Main St Elkridge 27 Md DATE SIGNED 2/22/60											
ACTUAL SIGNATURE B B Brumbaugh				PHYSICIAN'S NAME (Type) B B Brumbaugh							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-60		22c. NAME OF CEMETERY OR CREMATORY Meadowridge				22d. LOCATION (City, town, or county) (State) Elkridge, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md						ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City - RURAL</u>			c. LENGTH OF STAY IN 1b <u>RFD#1, Ellicott City</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shaffers' Convalescent Retreat</u>			e. STREET ADDRESS <u>Bonnie branch Road</u>		
3. NAME OF DECEASED (Type or print) <u>E. Clark</u> First <u>CLARA</u> Middle <u>L.</u> Last <u>Seicke</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-88</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>19</u> Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>Jacob Ammenhenuser</u>			14. MOTHER'S MAIDEN NAME <u>Louise</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Edward Kreis, Ellicott City, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>Pathologic fracture, left femur, 4 wks. prior to death</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Pathologic fracture, left femur, 4 wks. prior to death</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
22d. LOCATION (City, town, or county) <u>Baets</u>		22e. (State) <u>Md</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MacNolt & Son Catonsville</u>			24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~cancel~~ ^{cancel} carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2091 CERTIFICATE OF DEATH

Reg. Dist. No. 02093

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Home		d. STREET ADDRESS 2915 Oak Hill Ave.	
3. NAME OF DECEASED (Type or print) First Louise Middle — Last WARNER		4. DATE OF DEATH Month FEB. Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Schneider		14. MOTHER'S MAIDEN NAME Katherine Zeller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address John L. Warner 2434 Brambleton Road.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 yr.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-27 , 19 53 , to 2-27 , 19 60 , that I last saw the deceased alive on 2-27 , 19 60 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Herbert M.D.		ADDRESS (Street, city or town, state) 46 Church Road DATE SIGNED 2-27-60	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/2/60	22c. NAME OF CEMETERY OR CREMATORY Druid Edge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR MAR 2 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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